Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

What Do Hospitals Do With HIV-Infected Staff?

To THE EDITOR: The debate over testing of hospital staff for antibodies to the human immunodeficiency virus (HIV) continues. Although the Centers for Disease Control has decided for the time being not to publish a list of high-risk procedures, it seems likely that decisions with regard to testing, and subsequent "management" of HIV-positive physicians and nurses, will be dealt with by local political jurisdictions or institutions.

In mid-1989, we conducted a national survey, "The HIV Testing Policies and Practices of U.S. Hospitals," which contained questions related to the presence of nonoccupationally infected staff. These telephone interviews also asked, if such persons were employed, what limitations the hospital placed upon their practice.

Of chiefs of the surgical services interviewed, 24 of 508 (4.7%), 41 of 506 chiefs of medical services (8.1%), and 60 of 558 directors of nursing services (10.8%) indicated the presence of at least one nonoccupationally infected staff member at their hospital. In total, 105 (or 18.8%) of the 558 hospitals in this sample had at least one member of their combined provider staffs who was HIV-antibody positive due to nonoccupational exposure. The presence of infected staff members was significantly higher in hospitals of urban areas of more than one million (30.1%) compared to medium-sized communities of 250,000 to one million (15.5%). Only 4.6% of hospitals in smaller communities of less than 250,000 had one or more infected staff members.

With regard to the actions taken, no hospital suspended an HIV-infected physician's staff privileges or discharged an HIV-infected nurse. In 20% to 30% of the hospitals, an infected physician's privileges were "sometimes" revoked. The major action taken with regard to nurses was restriction of patient contact to certain procedures.

While these data are 2 years old, it is clear that HIV testing of all medical and nursing staff members, particularly those of hospitals in large urban areas, will reveal the presence of persons who have been nonoccupationally infected with HIV. It is less clear how much progress has been made in the past two years in developing formal policies for dealing with these persons. Those advocating testing should be prepared to propose specific policies and procedures for dealing with the results of their testing in ways that will protect providers as well as patients, since such testing *will* reveal HIV-positive providers of care in many hospitals.

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The 'Gag' Rule—A Freedom of Speech Issue?

To THE EDITOR: If the "gag" rule is not a freedom of speech issue, what is? When Dr Hammons says in her letter published in the December issue[1] that she does not want her "tax dollars spent in this manner," she is saying not that she doesn't wish to subsidize abortions—because it isn't the gag rule that stops that—but that she doesn't wish to subsidize information about legal options for pregnant patients. Partial information is only partial care, unless one believes that doctors or the government should make decisions for patients. Health care providers who tell only part of the truth should be required to wear warning labels such as "Caution! I may not tell you everything you need to know to make an informed decision." Then a patient can know what she's dealing with.

What would Dr Hammons think about this kind of rule being applied to her information sources? First, President Bush could decide that libraries or departments in institutions receiving federal funds cannot supply information on abortions to their staffs. Then, maybe birth control information gets "gagged." Then, who knows?

No, Dr Hammons, this *is* about freedom of speech.

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REFERENCE

1. Hammons L: Taxes and abortion (Correspondence). West J Med 1991 Dec; 155:663

How Important Is a Name?

To THE EDITOR: "What's in a name?" wrote Shakespeare, "A rose by any other name would smell as sweet." There may—Shakespeare notwithstanding—be lots in a name. A name can carry dignity but also suggest an insult, connote degradation, or paint a dismal picture. So the rose may smell as sweet by any other name, but the loss of that name may take away some of its beauty.

The designations "physician," "nurse," "physiotherapist," and other terms applied to medical professionals not only describe their positions but, as well, their function in health care. Substituting the word "provider" takes away the substance of these well-earned titles and lumps their functions in a generic pile. In doing so, it extracts the important implications of trust, caring, and warmth.

A patient must have a close relationship with a physician, must have trust, loyalty, and confidence, all of which rolls into "my physician." The word must sit on the head of a distinct person, separated from all others. It is easy for a person to say meaningfully, "My physician was with me and saw me through the dark hours," but it does not have the same ring if we substitute "provider."

Living in an atmosphere of experimental welding of medicine and industry and buffeted by government and insurance companies, a new language is being thrust upon us to describe some old and some new relationships. This, in some